MassHealth Update

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A Newsletter for MassHealth Providers

New Implementation Date for the New Medicaid Management Information System (NewMMIS)

The NewMMIS implementation date has been rescheduled to early January 2009, allowing MassHealth to continue internal testing to ensure that the new system functions as designed, and giving MassHealth providers more time to prepare for the transition to NewMMIS.

Additionally, as a result of the rescheduled implementation, the issuance of the new MassHealth Member identification cards, as explained in the article on page 3 of this newsletter, will be rescheduled. Please continue to check this page regularly for updates and related provider bulletins.

Although the implementation date has changed, it does not mean that you should stop or relax your preparation activities for implementation. You should continue to:

- review HIPAA companion guides;
- review billing instructions;
- prepare your systems for billing paper and electronic claims;
- coordinate with billing intermediaries and software vendors;
- prepare your operations for implementation; and
- attend NewMMIS information and training sessions.

The NewMMIS Pilot will run from mid-August to mid-September. This project will involve 30 pilot providers who will submit live direct data-entry (DDE) transactions through the Provider Online Service Center and send Health Insurance Portability and Accountability Act (HIPAA) batch transactions through the application. Feedback from this project in late September will provide important information on the status and expected integration of the NewMMIS.

Additionally, MassHeatlh will initiate Trading Partner Testing (TPT) of HIPAA batch transactions with up to 300 MassHeatlh trading partners. These trading partners have been contacted individually. TPT for these 300 testers will begin in late August.

Check for Updates

MassHealth will continue to issue additional provider communications and updates on the NewMMIS implementation through message text, the *Update* provider newsletter, and the NewMMIS Web page at www.mass.gov/masshealth/newmmis.

MassHealth thanks providers for their continued support and participation in this transition process.

Reminder to Use a Modifier When Submitting Claims for the Use of a Standardized Tool to Screen for Behavioral-Health Needs of Children Under the Age of 21

Effective December 31, 2007, MassHealth implemented new requirements for behavioral-health screenings for MassHealth children under the age of 21. This applies to all MassHealth members under age 21, except for those enrolled in the MassHealth Limited coverage-type. All MassHealth primary-care providers are required to offer a behavioral-health screening using a MassHealth-approved standardized screening tool at each Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Pediatric Preventive Healthcare Screening and Diagnosis (PPHSD) visit required by the EPSDT Medical Protocol and Periodicity Schedule (see Appendix W in all MassHealth provider manuals).

Behavioral-Health Screens: Service Code with Modifier and Billing

Primary-care providers who conduct behavioral-health screens with a standardized screening tool according to Appendix W (EPSDT Services Medical Protocol and Periodicity Schedule) will receive a separate payment for the screen in addition to the rate of the visit. As specified in Appendix Z of all MassHealth provider manuals, primary care providers should bill using Service Code 96110 for developmental testing, such as Developmental Screening Test II, Early Language Milestone Screen, with interpretation and report.

Use a U-Modifier with Service Code 96110

To claim payment for the behavioral-health screening, MassHealth-enrolled providers must bill using Service Code 96110 and the appropriate billing modifier. The billing modifier (U-modifier) depends on the type of provider who conducted the screen and the disposition of the screen (whether the screen identified, according to the clinician's professional judgment,

Reminder to Use a Modifier When Submitting Claims for the Use of a Standardized Tool to Screen for Behavioral-Health Needs for Children Under the Age of 21 (cont.)

a potential behavioral-health services need). In the future, failure to include a modifier with a claim for Service Code 96110 will result in a claim denial.

The U-modifiers vary by provider type and are designed to relay clinical information to MassHealth. The U-modifiers allow MassHealth to track when the provider of the screening tool, in her or his professional judgment, identifies a child with a potential behavioral-health service need. Billing intermediaries need to check with the provider or office staff or the medical record before inserting a U-modifier, to ensure that the correct clinical information is relayed to MassHealth.

U-Modifiers for Use with Service Code 96110

The following section lists the U-modifiers to use when the provider administering the screening tool, in her or his professional judgment, identifies a child with a potential behavioral-health services need.

When no behavioral-health need is identified, the following provider types should use the modifiers indicated.

- physician, independent nurse midwife, independent nurse practitioner, community health center (CHC), outpatient hospital department (OPD): U1
- nurse midwife employed by physician or CHC: U3
- nurse practitioner employed by physician or CHC: U5
- physician assistant employed by physician or CHC: U7

When a behavioral-health need is identified, the following provider types should use the following modifiers.

- physician, independent nurse midwife, independent nurse practitioner, CHC, outpatient hospital department (OPD): U2
- nurse midwife employed by physician or CHC: U4
- nurse practitioner employed by physician or CHC: U6
- physician assistant employed by physician or CHC: U8

MassHealth Provider Manuals

Provider manuals are available in the online MassHealth Provider Library at www.mass.gov/masshealthpubs by selecting the Provider Manuals link. Providers can also review Appendix Z (under the Provider Manuals Appendices link) and Subchapter 6 in your provider manual for more information on the codes and modifiers.

Training

MassHealth has created a Web curriculum to educate primary-care providers on how to use the standardized behavioral-health screening tools for children under the age of 21.

The curriculum is available on the Children's Behavioral Health Initiative (CBHI) Web site at www.mass.gov/masshealth/childbehavioralhealth by selecting the Training for Providers link.

MassHealth Fraud Hotline Launched

The Deficit Reduction Act of 2005 bolstered the Centers for Medicare & Medicaid Services (CMS) ability and authority to hold states accountable for fighting Medicaid fraud and reducing any Medicaid waste and abuse. To accommodate this new legislation, MassHealth created an Operations Integrity Unit in 2007. One of the initiations of this unit was the introduction of a new fraud hotline.

The new Fraud Hotline is accessible at 1-877-437-2830. The Hotline answers calls received between 8 A.M. and 5 P.M., Monday through Friday.

After hours, weekend and holiday calls are received by a voicemail system. This system can be used by anyone who suspects identification theft, member, and/or provider fraud, or to voice concerns or report suspicions of fraud, waste, and abuse.

The MassHealth fraud hotline number is 1-877-437-2830.

To raise awareness of the Fraud Hotline, MassHealth members will receive notice of the hotline with their new MassHealth ID cards and member booklets.

Don't forget—if you suspect fraud, call the Fraud Hotline at 1-877-437-2830!

Institutional Claims and National Drug Code (NDC) Requirement

To meet compliance standards outlined in the Deficit Reduction Act (DRA) of 2005, effective September 15, 2008, MassHealth will require providers using institutional claim forms to submit national drug codes (NDCs) with NDC units and appropriate descriptors to accompany claims for outpatient drugs paid using Healthcare Common Procedure Coding System (HCPCS) Level II codes. This requirement generally affects chronic rehabilitation hospitals, renal dialysis clinics, and out-of-state acute hospitals, and includes Medicare crossover claims.

This requirement does not apply to claims that are paid as part of a bundled rate, such as the claims paid through the Payment Amount Per Episode (PAPE). It does not apply to vaccines, radiopharmaceuticals, or contrast media at this time.

Claims that do not have this information will be denied or subject to recoupment.

MassHealth's coverage and pricing procedures have not changed with regard to medications administered in these clinical settings. The purpose of this requirement is to allow MassHealth to collect rebates from drug manufacturers.

Instructions for Billing

Following the same procedures for using HCPCS code and service units as previously used, providers should add NDC and NDC-quantity information as explained below. Instructions for billing electronically and on the UB-04 are provided.

Electronic Billing Procedures

If you bill electronically using the 837 transaction, complete the Drug Identification and Drug Pricing segments in Loop 2410 following the instructions below.

2410 LIN 02: Product or Service ID Qualifier:

- If billing for a national drug code (NDC), enter the product or service ID qualifier.

2410 LIN 03: Product or Service ID:

- If billing for drugs, include the NDC.

  An NDC is not required for vaccines.

2410 CTP 03: Unit Price:

- If an NDC was entered in LIN 03, include the unit price for the NDC billed.

2410 CTP 04: Quantity:

- If an NDC was submitted in LIN 03, include the quantity for the NDC billed.

2410 CTP 05-1: Unit or Basis for Measurement Code:

- If an NDC was submitted in LIN03, include the unit or basis for measurement code for the NDC billed using the appropriate code qualifier:
  - F2 — International unit
  - GR — Gram
  - ML — Milliliter
  - UN — Unit

Refer to Chronic Outpatient Hospital Bulletin 4, Renal Dialysis Clinic Bulletin 4, and Acute Outpatient Hospital Bulletin 4 in the online MassHealth Provider Library for more information.

If you bill on paper, use the following instructions for completing the revenue description field (form locator 43) on the UB-04.

- Report the N4 qualifier in the first two positions, left-justified and include the 11-character NDC number in the 5-4-2 format (no hyphens).
- Immediately follow the last digit of the NDC (no delimiter) with the unit of measurement qualifier. The unit of measurement qualifier codes are listed below.
  - F2 -International Unit
  - GR-Gram
  - ML-Milliliter
  - UN-Unit
- Immediately following the unit of measurement qualifier, you will find the unit quantity with a floating decimal for fractional units limited to three digits (to the right of the decimal).
- Any spaces unused for the quantity should be left blank.

Please Note: The decision to make all data elements left-justified was made to accommodate the largest quantity possible.

The description field on the UB-04 is 24-characters in length. An example of the methodology is illustrated in the provider bulletins.

When billing Medicare for a dual-eligible individual, providers should enter the NDC and units on their claim (paper or electronic) in the appropriate fields mentioned above. This is applicable to claims submitted directly to MassHealth and to claims that will cross over from the Medicare coordination-of-benefits contractor to MassHealth.

Although MassHealth is not changing billing instructions about the reimbursement at this time, these instructions can also be found in bulletins for affected providers (Chronic Outpatient Hospital Bulletin 4, Renal Dialysis Clinic Bulletin 4, and Acute Outpatient Hospital Bulletin 4). You can also find information about billing for all physician-administered drugs, including professional claims, in a Web document entitled "National Drug Code (NDC) Requirements for Physician Administered Medication" by going to the MassHealth Web site at www.mass.gov/masshealth and clicking on the Information for MassHealth Providers link. The link for the document is located at the bottom of the page.

Dental Bulletin 39

MassHealth Dental Bulletin 39 (July 2008) clarifies those dental services covered by MassHealth-contracted managed-care organizations (MCOs), those dental services that are not, and those that may be covered by the MassHealth dental program. This bulletin supersedes the information transmitted in Dental Bulletin 23 (June 1999).

MCO covered MassHealth-contracted MCOs cover the following dental services:

- emergency-related dental services that are furnished to an enrollee by a provider qualified to furnish such services under Title XIX of the Social Security Act, and that are needed to evaluate or stabilize an enrollee's emergency medical condition; and
- oral surgery performed in an outpatient hospital setting or ambulatory surgery setting when it is medically necessary to treat an underlying medical condition.

Examples of an underlying medical condition could include situations where the individual has a heart condition that requires close monitoring in an outpatient hospital setting, or situations where the individual has an underlying behavioral-health issue that requires the procedure to be performed in an outpatient hospital setting.

When these MCO-covered dental services are furnished, providers should bill the appropriate MassHealth-contracted MCO.

Dental services not mentioned above may be covered by the MassHealth dental program, if the services were performed by a MassHealth dental provider in accordance with all MassHealth regulations, including those at 130 CMR 420.000 and 450.000. This includes preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health. When these MassHealth-covered dental services are furnished, MassHealth dental providers should bill MassHealth.

If you have questions about the MCO-covered dental services discussed in this bulletin, providers should contact the appropriate MCO Customer Service Center listed below.

- Boston Medical Center HealthNet Plan: 1-888-566-0008 or 1-800-900-1451
- Fallon Community Health Plan: 1-866-275-3247
- Network Health: 1-888-257-1985
- Neighborhood Health Plan: 1-800-462-5449

If you have more questions on the covered dental services, contact MassHealth Dental Customer Service at 1-800-207-5019.

MassHealth Reminders

National Provider Identifier and Crossover Part B Payment Issue

As a result of a Medicare Part B crossover claims issue recently identified, MassHealth has determined that claims submitted by facilities (outpatient and inpatient hospitals, community health centers, hospital-licensed health centers) or groups may have incorrectly paid to the rendering (servicing) physician listed on the claim. For additional information and instructions on how to resolve these incorrectly paid claims, please visit www.mass.gov/masshealth. Click on Information for MassHealth Providers, and then click on Important Information About Medicare/MassHealth Crossover Claims.

New Provider Publication

MassHealth issued the following provider publications for group practice organizations: Transmittal Letter (TL) PHY-121, TL ALL-158, All Provider Bulletin 175, and All Provider Bulletin 176. These publications are available for download from the online MassHealth Provider Library located at www.mass.gov/mashealthpubs by selecting the MassHealth Provider Library link.

Ambulance Providers

Final Deadline Appeals for Ambulance Claims Submitted with Service Code A0434

For ambulance providers submitting a final-deadline appeal for claims with Service Code A0434 for dates of service that exceed 12 months (or 18 months with another insurer involved), the claim must have appeared on a remittance advice (RA) with error code "888" (Final Deadline Exceeded). The appeal must be submitted to the final deadline appeals board within 30 days of the date on the RA on which the claim first appeared with error code "888." Appeals submitted without a denial for error code 888 will be returned.